Congress Passes Two Bills of Importance to Ambulance Services
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S.459 - Hometown Heroes Survivors Benefits Act of 2003
The federal Public Safety Officer Death Benefits (PSODB) program provides death benefit payments to the families of police officers, fire fighters and medics who are killed in the line of duty. This bill modifies that program and establishes a presumption of death in the line of duty when a qualified individual dies as a result of a heart attack or stroke within 24 hours of working a shift. The PSODB program applies only to those public safety personnel employed by units of government. The families of medics employed by independent and hospital-based ambulance services are not covered under the plan and do not receive the federal death benefit. The American Ambulance Association has been pushing for a definition change (HR1475) that would qualify non-government fire and ambulance personnel, but the definition change was not included in the bill.
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H.R.1 - Medicare Prescription Drug and Modernization Act of 2003

Notably Missing: Both the House and Senate passed prescription drug bills contained a provision to eliminate the "isolation test" for Critical Access Hospitals that own and operate ambulance services to receive cost-based reimbursement. This provision was NOT included in the final conference committee bill.

Section 414- All provisions take effect July 1, 2004

CBO Score: $600,000,000

New Regional Fee Schedules: July 1, 2004 through December 31, 2010. Instead of one national Medicare ambulance fee schedule, there will be regional ambulance fee schedules based on census regions. Both base rates and mileage are affected. Providers in a region who would be harmed under the new regional fee schedules will be held harmless and they will remain on the national fee schedule and their 100% phase in will remain 2006. For those ambulance services who would be helped by regional fee schedule, they will transition until 2010, when they will be on the permanent fee schedule. Here's how it works: In 2004 the national Medicare fee schedule ambulance payments are blended 60% fee schedule, 40% old method. Providers helped by a regional fee schedule will have the 60% side of that equation (the 40% side is not impacted) further blended using 20% of the national fee schedule and 80% of the regional rate. In 2005 when the national fee schedule transition is 80% and the old rate 20%, providers helped by the regional fee schedule will be blended on the 80% side at 40% fee schedule and 60% regional rate. In 2006 when the national fee schedule is 100%, they will be blended 60% fee schedule and 40% regional rate. In 2007-2009 they will be blended 80% fee schedule and 20% regional rate. In 2010, everyone is at the fee schedule. The regional fee schedule rates will be determined by a review of historical charges. Associations like the American Ambulance Association are expected to release an analysis of the predicted regional fee schedule rates next week.

Long trips: Permanent Change. Miles 50 and above will be paid at 1.25 times

the urban mileage rate for both urban and rural ambulance runs. [Note: the 1.25 current rural modification on miles 18-50 was a temporary change and it expires January 1, 2004. It was NOT renewed in the bill.] Rural Transports: Miles 1-17, 1.5 times urban, miles 18-49 urban, miles 50+ 1.25 times urban. Urban Transports: Miles 1-49 urban, miles 50+ 1.25 times urban.

Rural Adjustments: Permanent Change. The language was changed from the original House passed bill. In the previous bill, help was targeted to the rural counties that had the lowest quartile population density. In the final bill, it was changed to all of the rural counties that together comprise the lowest quartile of rural population density. The net impact is that more rural counties will benefit. Associations like the American Ambulance Association are expected to release an analysis of the predicted counties that qualify and the amount the week of December 1st.

Fee Schedule Update: July 1, 2004 through December 31, 2006. Urban ambulance services will receive CPI + 1% and rural ambulance services will receive CPI + 2%.

GAO Report: By December 31, 2005, the US General Accounting Office must submit a report to Congress on how costs differ among types of ambulance providers and on access, supply and quality of ambulance service in regions and states whose rates under the fee schedule are less than they were before the fee schedule began implementation.

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Section 415- Effective January 1, 2005

CBO Score: $100,000,000

Permanent Change. This section removes some discretion from Medicare payment contractors (carriers and fiscal intermediaries) who are currently down-coding air ambulance claims to ground rates, but only for rural air ambulance runs. If the service meets coverage criteria, is reasonable and necessary, and an air ambulance complies with equipment and crew requirements, if air ambulance is specifically requested by a physician or other qualified medical person who certifies the patient's condition needs air transport the test of medical necessity under Medicare is deemed to be met. Likewise, for rural air ambulance runs that are performed under protocols established by a state or regional EMS agency, the medical necessity test is met - provided the state or regional EMS agency is not the operator of the air ambulance. There are also some limitations in cases where there is common ownership between the requesting facility and the air ambulance operator.

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Section 1011- Starts Federal Fiscal Year 2005

Effective Federal Fiscal Years 2005-2008. Under this provision, $250 million for each of the 3 years was set aside to provide federal reimbursement for emergency health services furnished to undocumented aliens. If not all of the funds are spent in a year, they carry forward to future years. There are a number of formulas for how the funds are

distributed in the language. The significance to EMS providers from this section is that ambulance service is eligible for reimbursement and ambulance services are eligible providers.
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